Mississippi Medicaid

Provider Reference Guide

For Part 205

Hospice

This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.

Table of Contents

Hospice Introduction

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Hospice care is an optional benefit under the state's Medicaid program. Beneficiaries enrolled in Mississippi Medicaid's Home and Community Based Waiver programs may not receive hospice benefits simultaneously. A hospice may be a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals.

To participate in the Mississippi Medicaid Program, a Hospice must:

- Meet the conditions of participation set forth in 42 CFR, Chapter IV Centers for Medicare & Medicaid Services, Department of Health and Human Services, Part 418

- Be licensed and certified for participation by the State survey agency, Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification (HFLC)

- Enter into a provider agreement with the Mississippi Division of Medicaid (DOM).

Provider participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, he/she must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Only services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary. DOM does not cover telephone contacts/consultations or missed/cancelled appointments, and providers may not bill beneficiaries for these services.

The Mississippi Medicaid program purchases needed personal health care services for beneficiaries as determined under the provisions of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

Program Overview

Admission to hospice and subsequent re-enrollment periods must be certified through the Division of Medicaid's Utilization Management and Quality Improvement Organization. Procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid (DOM).

Hospice Services

Hospice provides palliative treatment that may include the following:

- Nursing care
- Medical social services
- Physician services
- Counseling
- Short-term inpatient care
- Medical appliances and supplies
- Drugs and biologicals
- Home health aide/homemaker
- Non-restorative therapies
- Respite Care, excluding a resident in a nursing facility or free-standing hospice

For Mississippi Medicaid purposes, palliative is defined as the relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement. Through this emphasis on palliative rather than curative services, beneficiaries have a choice whenever conventional approaches for medical treatment may no longer be appropriate.

The medications prescribed for hospice beneficiaries must be palliative in nature and prescribed for an end of stage of life disease diagnosis. All palliative therapy, including medication used to treat the beneficiary's terminal illness, must be billed to the hospice provider, i.e., DOM reimburses for only those medications that are not directly related to the beneficiary's terminal illness and that are within the applicable DOM prescription service limits.

Exceptions for Children Under the Age of 21

According to the Patient Protection and Affordable Care Act of 2009 for Hospice, children under the age of 21 may receive hospice benefits including curative treatment upon the election of the hospice benefit without foregoing any other service to which the child is entitled under Medicaid.

Enrollment and Election Periods

The hospice benefit is divided into distinct periods as outlined in the Balanced Budget Act of 1997. Each period stands alone, and once used, is never again available. A period is used when the beneficiary enrolls in that period and subsequently dis-enrolls, or when the maximum number of days available in that period is used. The maximum number of days in each election period is as follows:

- 1st – 90 days
- 2nd – 90 days
- 3rd – 60 days - unlimited increments

To be eligible to elect hospice care under Medicaid, the beneficiary must be certified as being terminally ill with a life expectancy of six (6) months or less, and there must be a documented diagnosis consistent with a terminal stage of six (6) months or less. The beneficiary must be certified/re-certified for each benefit period. The beneficiary must acknowledge the terminal illness and elect to receive the palliative care of the hospice services rather than active treatment of the terminal condition. The Election Package at a minimum must be completed in order for the beneficiary to be enrolled in the Medicaid Hospice program.

The Election Package includes:

- The Election Statement (DOM-1165-A) signed by the beneficiary,
- The original document of each enrollment period signed by the beneficiary/legal representative; and the original election statement signed by the beneficiary/legal representative and the hospice provider

- The Enrollment Form (DOM 1165-B) completed by the hospice provider
- Physician's Certification/Re-certification (DOM 1165-C), with appropriate signatures for each enrollment period
- A physician's certification and diagnosis consistent with a terminal stage of six (6) months or less must be documented

Plan of Care

Services must be provided under a written plan of care (POC). The POC must be established by the hospice's interdisciplinary team before hospice care is provided and it must be reviewed/revised as specified in Provider Policy Manual Section 14.03 Physician Certification/Re-Certification and Plan of Care.

Physician Certification/ Recertification and Plan of Care

Plan of Care

Services must be provided under a written plan of care (POC). The POC must be implemented by a registered nurse and established by the hospice's interdisciplinary team/group (IDT or IDG) before hospice care is provided. The plan must include a comprehensive assessment of the beneficiary's needs and identification of the care/services including the management of discomfort and symptom relief. The POC must state in detail the scope and frequency of services needed to meet the beneficiary's and family's needs. If the beneficiary is a resident in a nursing facility, the POC should be coordinated between the nursing facility provider and the hospice provider to ensure continuity of care. The POC must be signed by all members of the IDT or IDG and be regularly reviewed and updated as stated below:

1. Within 48 hours of the admission, a written plan of care must be developed for each beneficiary/family by a minimum of two (2) IDT or IDG members and approved by the full IDT or IDG and the Medical Director at the next meeting. The care provided to a beneficiary must be in accordance with the POC.

2. The plan of care is reviewed and updated at intervals specified in the POC, when the beneficiary's condition changes and a minimum of every 14 days for home care and every 7 days for general inpatient care, collaboratively with the IDT or IDG.

3. The hospice must retain the POC in the beneficiary's medical record. This must be maintained at the hospice site issued the provider license and DOM provider number.

Interdisciplinary Team or Group Description and Involvement:

An interdisciplinary team (IDT) or group(s) (IDG) designated by the hospice is composed of representatives from all the core services. The IDT/IDG must include at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The IDT/IDG is responsible for participation in the establishment of the plan of care; provision or supervision of the hospice care and services; periodic review and updating of the plan of care for each beneficiary receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services. The IDT/IDG is required to hold regularly scheduled meetings to review the most current beneficiary/family assessment, evaluate care needs, and update the plan of care.

Beneficiary Election Requirements

The beneficiary/legal representative must elect hospice care in order to receive it. To elect hospice, the beneficiary/legal representative must sign and file an Election Statement with the hospice. The signed Election Statement (DOM 1165-A) allows Medicaid to make payments for hospice care in lieu of payments made for treatment of the condition for which hospice care is sought.

Waiver of Medicaid Services

When a hospice benefit period is completed or the remaining days in that period are revoked, the beneficiary's waiver of all other Medicaid services ceases and all benefits under the Medicaid program, to the limits permitted, are again available.

Revocation and Change of Hospice

Revocation

The beneficiary/legal representative may revoke the election of hospice care at any time by filing a Disenrollment/Transfer Form (DOM-1166) to disenroll from the current benefit period. The form must reflect the effective date of revocation from hospice election. Disenrollment from hospice is required for, but not limited to, the following:

- Death
- Hospitalization unrelated to terminal illness
- Beneficiary is seeking treatment other than palliative in nature
- Beneficiary no longer meets program requirements

The Disenrollment/Transfer Form (DOM-1166) must be completed, signed and dated, filed in the beneficiary's medical record, and a copy transmitted to DOM's designee within forty-eight (48) hours of the disenrollment. Failure to comply will result in the hospice being held responsible for any or all charges incurred by the beneficiary. The beneficiary forfeits coverage for any remaining days in that election period. The beneficiary may not designate an effective date earlier than the date that the revocation was made. For re-enrollment of a beneficiary after disenrollment, the hospice must provide all certification documentation as required for the appropriate certification period.

When the election of hospice care for a particular election period is revoked, the beneficiary resumes Medicaid coverage of the benefits waived when hospice care was elected. The beneficiary, may at any time, elect to receive hospice services for any other hospice election periods for which he/she is eligible.

If a beneficiary is eligible for Medicare as well as Medicaid, the hospice benefit and each period therein, must be elected and revoked simultaneously under both programs.

Change in Hospice Designation

The beneficiary may change the designation of hospice care once per election period. A change in the designated hospice is not considered a revocation of the election.

To change the designation of the hospice provider the beneficiary must file a signed statement with the current hospice and with the newly designated hospice. Each hospice provider must provide the other with a copy of the signed statement and both must file both statements in the beneficiary's medical record. The signed statements must include the following information:

- The name of the current hospice provider from whom the beneficiary has been receiving care
- The name of the new hospice provider from whom the beneficiary plans to receive care
- The date the change is effective. Medicaid will not reimburse for the date of discharge, transfer or the date of death.

The current hospice provider must complete the Disenrollment/Transfer Form (DOM-1166) on the beneficiary's last date of service and the new hospice provider must complete the Election Package (DOM 1165 A,B, and C) on the next date of service. All forms must be sent to DOM's designee. Hospice change of ownership is not considered a change in the beneficiary's designation of a hospice and requires no action on the beneficiary's part.

Refer to http://www.medicaid.ms.gov/providerforms.aspx to retrieve a copy of the Election Package and Disenrollment/Transfer forms.

Dual Eligibles

Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid (dual) eligible.

Medicare is the primary coverage for dual eligible beneficiaries; however, the hospice benefit is used simultaneously under both programs. The hospice benefit, and each period therein, is available only once in a lifetime for dual eligible beneficiaries. Conversely, the hospice benefit and each period therein, must be elected and revoked simultaneously under both programs.

For information on "Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles" for Part A crossover claims, refer to Administrative Code Part 200 Chapter 2.

Covered Services

Core hospice services include physician services, nursing care, medical social services, and counseling services. All core services must routinely be provided by hospice employees with the exception of physician services, which may be contracted as outlined in section 4445 of the Balanced Budget Act of 1997. Supplemental services may be contracted for during periods of peak beneficiary loads and to obtain physician specialty services. All personnel must meet applicable state and federal licensing/certification requirements.

- Physician services performed by a physician as defined in 42 CFR 418. (Exception: the services of the hospice medical director or the physician member of the interdisciplinary group, must be performed by a doctor of medicine or osteopathy).

- Nursing care provided by a registered nurse (RN). The RN shall identify the beneficiary/family's physical, psychosocial, and environmental needs and reassess as

needed but no less than every 14 days at the beneficiary's residence. When aide services are being provided, the registered nurse will make supervisory visits to the beneficiary's residence at least every other week to provide direct supervision, assess relationships, and evaluate care plan goals. For the initial visit, the RN must accompany the nurse aide.

- Medical social services provided by a licensed social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

- Counseling services provided to the terminally ill beneficiary and the family members or other persons caring for the beneficiary at home.

- Counseling, including dietary counseling, may be provided to train the beneficiary's family or other caregiver, and for the purpose of helping the beneficiary and those providing care to adjust to the beneficiary's approaching death.

- Medical appliances and supplies, drugs, and biologicals.

- Medical appliances and supplies, drugs, and biologicals that are used primarily for the relief of pain and symptom control related to the beneficiary's terminal illness are covered per the approved written plan of care. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the beneficiary's terminal illness. Equipment is provided by the hospice for use in the beneficiary's home.

- Hospice aide services furnished by qualified aides and homemaker services.

- Hospice aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the beneficiary, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the beneficiary. Aide services must be provided under the general supervision of a registered nurse. The RN must visit the beneficiary's residence at least every two (2) weeks when aide services are being provided, and the visit must include an assessment of the aide services.

- Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the beneficiary to carry out the plan of care.

- Physical therapy, occupational therapy, and speech-language pathology services may be provided for purposes of symptom control or to enable the beneficiary to maintain activities of daily living and basic functional skills.

When a beneficiary qualifies for state plan services and chooses to be certified for hospice end of life services, the services available under the hospice benefit may not be duplicated by another Medicaid program.

Special Requirements Coverage

Continuous Home Care Continuous home care may be provided only during a period of crisis. A period of crisis is defined as a period in which a beneficiary requires continuous care, primarily nursing care, to achieve palliation or management of acute medical symptoms. The medical record must include specific documentation for each day of the crisis period.

The hospice must provide a minimum of eight (8) hours of care by a Registered Nurse (RN) during a 24-hour day that begins and ends at midnight. This care need not be continuous e.g., four (4) hours could be provided in the morning and another four (4) hours in the evening. However, a combined total of eight (8) hours of nursing care is required. Services provided by a Nurse Practitioner (NP) that, in the absence of a NP, would be performed by an RN will be paid at the same continuous home care rate. LPN (Licensed Practical Nurse), homemaker, or aide services may be provided to supplement the nursing care.

Continuous home care is covered when it is provided to maintain the beneficiary at home during a medical crisis. If less skilled care (less than eight (8) hours of R.N. care) is needed on a continuous basis to enable the beneficiary to remain at home, it is covered as routine home care. Continuous home care may not be provided when the hospice beneficiary is a nursing home resident or an inpatient of a free-standing hospice.

Respite Care

Respite care is short-term inpatient care provided to the beneficiary only when necessary to relieve the family members or other persons caring for the beneficiary at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five (5) consecutive days at a time.

Respite care may not be provided when the hospice beneficiary is a nursing home resident is an inpatient of a free-standing hospice, or the services are a duplication of any other like services being delivered to the beneficiary.

Bereavement Counseling

Bereavement counseling consists of counseling services provided to the beneficiary's family after the beneficiary's death up to twelve (12) months. Bereavement counseling is a required hospice service, but it is not reimbursed separately.

General Inpatient Care

Short-term inpatient care may be provided in a participating hospice inpatient unit, hospital, or a participating SNF or NF that additionally meets the special hospice standards regarding patient and staffing areas. General inpatient care may be required for procedures necessary for pain control or acute symptom management which cannot feasibly be provided in other settings. Services provided in an inpatient setting must conform to the written plan of care and the medical record must include specific documentation for each day of the crisis period.

Reimbursement

With the exception of payment for attending physician services, Medicaid reimbursement for hospice care is made at one of four (4) predetermined rates for each day that the beneficiary is under the care of the hospice. The state's Medicaid rates are established once each year based on the national rates published annually for the Medicare hospice program and adjusted for the wage index of the location where the hospice service is provided**.** The rates are prospective rates. The rate paid for any particular day varies depending on the level of care furnished to the beneficiary.

Levels of Care

The four (4) levels of care are as follows:

HOSPICE SERVICES	**UB REVENUE CODE**
Routine Home Care	651
Continuous Home Care	652
Inpatient Respite Care	655
General Inpatient Care	656

NOTE: For information on beneficiaries residing in a nursing facility (Revenue Code 659) refer to: "Reimbursement for Beneficiaries in a Nursing Facility" in this section of the manual.

Each day that the beneficiary is under the care of a hospice, Medicaid will reimburse the hospice an amount applicable to the type and intensity of the services furnished to the beneficiary for that day. For continuous home care, a registered nurse must have provided a minimum of eight (8)

hours of direct nursing care to the beneficiary during that day regardless of any other services that may have been rendered.

Respite and general inpatient days are payable to the hospice. The hospice is responsible for reimbursing the facility that provides the inpatient care.

Date of Discharge

Medicaid will not reimburse for the date of discharge or the date of death.

Reimbursement for Physician Services under Hospice

The basic reimbursement rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. The physician serving as the medical director and the physician member of the hospice interdisciplinary group generally performs these activities. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

Medicaid does not reimburse the hospice separately for hospice physician services, except for coinsurance payments that result from Medicare approved claims. Medicaid will pay the claims of attending physicians for direct patient care services to beneficiaries that elect the hospice option as long as such services are not routinely provided to the hospice's patients on a voluntary basis.

In determining which services are furnished on a voluntary basis and which services are not, a physician must treat Medicaid beneficiaries on the same basis as other patients in the hospice. For example, a physician may not designate all physician services rendered to non-Medicaid patients as voluntary and at the same time seek payment from Medicaid for all physician services rendered to Medicaid beneficiaries.

NOTE: Unless the attending physician has an agreement with the hospice to serve on a volunteer or contracted basis, the only services that may be billed by the attending physician are the physician's personal professional services.

Reimbursement for Beneficiaries in a Nursing Facility

For DOM purposes, beneficiaries residing in a nursing facility may elect to receive hospice benefits and the nursing facility may be considered the beneficiary’s place of residence. In

addition to the hospice reimbursement for services, the hospice may also receive reimbursement for room and board. Room and board will be reimbursed to the hospice at 95% of the nursing home's established Medicaid per diem. The hospice must reimburse the nursing facility.

The nursing facility must still reflect the beneficiary as a resident. The hospice and the facility must have a written agreement under which the hospice is responsible for the professional management of the beneficiary's hospice care and the facility agrees to provide room and board to the beneficiary. All services included in the nursing facility per diem rate will not be reimbursed separately to the hospice.

The nursing facility where the beneficiary resides is responsible for completing a DOM-317 form when the beneficiary is admitted, transferred, discharged or expires in the facility. The DOM-317 form documents the most recent date of Medicaid eligibility and the amount of Medicaid income (beneficiary liability) due from the beneficiary each month. Medicaid income is the amount of money the beneficiary in the nursing facility must pay toward the cost. The nursing facility must provide the hospice provider with a verbal/written monthly account of the beneficiary Medicaid income.

The hospice provider must submit claims to DOM for reimbursement of the room and board and other hospice covered services. The beneficiary's Medicaid income will be deducted from the hospice provider's reimbursement. The hospice provider will be responsible for ensuring that the beneficiary's Medicaid income is collected for the hospice dates of service provided while the beneficiary is residing in the nursing facility. If the beneficiary is Medicaid only, DOM will reimburse for revenue codes 651 and 659. If the beneficiary is a dual eligible, DOM will reimburse for revenue code 659.

DOM does not reimburse the hospice provider for nursing facility bed-hold days.

It is the responsibility of the hospice and the nursing facility to coordinate billing and payment distribution for services provided to the Medicaid beneficiary.